Community Pharmacies: from dispensing drugs to pharmaceutical care. Actors involvement in the wider health service network.

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Abstract

All over Europe the index of evolution toward a pharmaceutical care approach of the community pharmacies shows rooms of improvement (Hughes C.M. et al. 2010) and in USA, MTM (Medication Therapy Management) has been put in place in order to help pharmacists to adopt practices inclined to patient surveillance, therapy compliance and generally speaking cognitive and personal care services to offer to the citizen and patient (Doucette W.R. et al., 2006).

In Italy a 2009's law introduced service offering in the pharmacies. The author administered an explorative survey aimed to assess the "sentiment" of these professionals in order to embrace the opportunity opened up by the new law (Nadin and Pacenti, 2011). Shadows and lights have emerged; one of the main issue, as detected as well as by international literature surveys, encompasses relationship with other health care operators such as GP (General Practitioners), specialists, therapists, nurses, etc.. The separated silos erected in the past among the operators do not facilitate the high level of communication required to manage, in a coordinated way, the patient pathology as in a networked perspective would be asked.

In this paper the author wants to investigate problems and opportunities related to the relationship between pharmacists and health care operators revisited in the light of the patient perspective.

Specified duties and responsibilities are required and clear stated but the optimization of the service offered to the patient walks through interchange and collaboration. Therefore it becomes pivotal to rethink correctly the degree of freedom and consequently the burden of risk between the operators. In this scenario technology evolution and ICT will enable in the future great opportunities for inter-organizational coordination. Patient's file sharing procedure offers a fundamental tool for inter-professional communication and can enable cooperation of the operator in the sake of the patient. Nevertheless we encounter many resistances and stickiness toward digitalization of the patient information as it involves problems of privacy, technical instances and, far more important, issues related to power and asymmetry information management among the operators.

The paper wants to cover these aspects of the relationship by the analysis of an experimental sample of dual relationship: physicians and pharmacists involved in medication therapy management (compliance, review of the therapy, drug to drug interaction, adverse effect of medication, etc.).

The relationship will be examined under the lens of the ARA model depicted by the IMP's school of though. Therefore the paper tries to outline actors bonds, resources involved and activities put in place by the operators to improve coordinated service to the patient and at the same time pursue their personal goals.

This paper must be intended as a first step analysis aimed to design a wider quantitative research focused on the collaboration among health care operators.

Thus first insights and findings will be discussed in the perspective of the designing the framework for an extensive research.

Introduction

Community pharmacies have historically played a well defined role in the broad sector of health services. While other operators had to take care of the health of the patient they had to dispense drugs required for treatments. This specialization is not anymore

sustainable as system efficiency is far from being optimized and modern societies have to face problems related to resource scarcity and significant increase of the health demand.

Health care is looking at the same effectiveness and efficiency because population is aging and therefore the demand of service will increase and because the resources that can be devoted to health services are reducing due to the crisis involving all the established economies.

One way to pursue these goals is to reshape the heath service network and particularly involve community pharmacies in the setting of primary care.

Pharmacies are generally speaking spread all over the territory and are near the citizen so they can easily be supportive for some ongoing activities related to pharmaceutical treatment. This would help to free existing resources (for instance physician's time devoted to assist patients) for others more specific and idiosyncratic activities such as diagnosis and therapy formulation. The involvement of pharmacists inside the primary care service is not an easy task as it requires reengineering of activities, rethinking of each actor role and willingness to an open collaboration with heterogeneous professionals and resources. This paper is devoted to investigate the problem of collaboration among pharmacists and physicians.

Collaboration among health care professionals has been defined as a joint communicating and decision-making process with the goal of satisfying the patient's wellness and illness needs while respecting the unique qualities and abilities of each professional. This definition can be reflected in relationships between physicians and pharmacists. Numerous studies have concluded that coordinated care between physicians and pharmacists can improve patient care outcomes. Nevertheless, the degree of collaboration that occurs between an individual physician and pharmacist can vary greatly. Inside the stream of researchers devoted to study pharmacies it has been defined a concept which is devoted to stigmatize the necessity to establish relationships among professionals devoted to provide health-care services. McDonough and Doucette (2001) have defined under the term of "collaborative working relationship" (CWR) the concept of collaboration among pharmacists, physicians, specialists, nurses, etc for the sake and to improve the outcomes for the patients.

The relationship is a multifaceted object which involves many factors, many of them often colliding: collaborative care, commitment, dependence symmetry or asymmetry, bidirectional communication, trust, initiating behavior, and conflict resolution.

Management sciences have deeply investigated around the term of business relationship. Here we want to find a viable approach to understand if the IMP approach can be fruitfully combined with CWR to understand the pharmacist-physician relationship and stigmatize any constituent of it. It is possible that patient health-care outcomes are related to the degree of collaboration between health-care providers; the analysis of it can help to improve total outcome, for patient and for the community as well.

Pharmacists have moral obligations to their patients. This claim alone is not very controversial; yet, the type and number of these obligations is controversial. The specific issue that has the greatest repercussions for pharmacy and society is whether or not the pharmacist's responsibility to his or her patients is dependent on the physician's responsibilities or independent from them.

It is the responsibility of both physicians and pharmacists to counsel patients regarding the shortcomings of their drug use, to decrease individual suffering and improve both clinical and humanistic patient outcomes as well as societal and economic.

It appears that the higher the pharmacist's involvement is in a patient's drug treatment the more the physician feels that the pharmacist is infringing on his/ her territory.

IMP framework

The IMP researchers employ the rainforest metaphor (Hakansson et al., 2009) to explain how business relationships (and in a wider perspective markets) are a context or networks in which operators are interested to develop interactions to thrive in a dynamic habitat which is in motion (Gadde and Hakansson, 2007).

Interaction are searched inside the typical micro-ambient of the company (customers and suppliers) but also by the interplay between other indirectly related parties such as financial institutions, public organizations, etc.. The authors focus the attention on the relationship overcoming the short term of analysis (cost and benefit) of each exchange. Therefore they outline the centrality of processes of both cooperation and conflict as products and services are produced and used. They highlight how tangible and intangible

resources of many types, stemming from many different organizational units, are related, confronted and adapted in ways which are beneficial for those involved in the doing of business.

Since relationships and networks of relationships are the core of the IMP group school, words as trust, cooperation, conflict, power, asymmetry, bilateral communication etc. are not only the foundation of the theory but form an entire body of knowledge in which the researcher is trying make them work together as relationships are complex and require multifaceted approaches to study them (Ritter and Ford, 2004, Gadde and Hakansson, 1993, Hakansson, 1982).

Pharmaceutical care, which asks the development of strong and wide relationships among operators of the health care setting can benefit from the IMP theoretical framework.

The basic model proposed inside the IMP school is the ARA model (Actors, Resources, Activities) (Hakansson and Snehota,1995).

The model is basically built on two points of view: the relationships, which are essentially constituted of three main elements (actors bonds, resources ties and activity links) and the investigation of them which may be done from a triple perspective: one single organization which tries to relate with others, the dyad side in which the focus is the interaction between two organizations alone and finally the network viewpoint who takes care of the interaction among all the actors involved in an open domain; the market.

In the context of this paper we focalized the attention only to the first of the element of the model named the actors. The others have not been taken in account in this paper since they do not seem to be, at a first sight, pivotal in a first attempt investigation. Therefore every consideration must be re-read under the lens of the incompleteness.

Pharmaceutical Care

Pharmaceutical care (PC) can be defined as the responsible provision of drug therapy for the purpose of achieving the definite outcomes that improve a patient’s quality of life (Helper and Strand, 1990).

Pharmaceutical care involves not only the supply of medicines but also advising patients with chronic diseases on their disease states and the drug therapy used to control their

conditions. A further aspect of pharmaceutical care is the implementation of a follow-up plan with the intention of monitoring the achievement of specific therapeutic objectives for the patient, e.g. reduction or elimination of symptoms of a disease state. A pharmaceutical care program should therefore include:

- consultation with the patient in order to evaluate their understanding of the drug therapy and identify drug-related needs.
- assessment of the patient's drug therapy to identify possible drug-related problems, e.g. side-effects, drug interactions, poor compliance.
- implementation of a monitoring schedule to ensure therapeutic goals and objectives are met and new drug-related problems do not arise.
- educating the patient on their disease state (including health promotion activities).
- pharmacists and other healthcare professionals working together to prevent, identify and solve drug-related problems.

In practice, therefore, pharmaceutical care means that the pharmacist's focus moves from the dispensing process to patient care and in doing so, pharmacists become more responsible for the outcome of drug therapy in their patients and must interact strongly with other professionals since the health status of the patient can be seen as the final stage of a process operated by many health-care professionals.

Here we want to concentrate on the relationship among Patient, Pharmacist and Physician because it is the core triad relationship in which to improve compliance, surveillance, detection of adverse side effects of drug, that are factors influencing effectiveness in health service (van Mil, 2010).

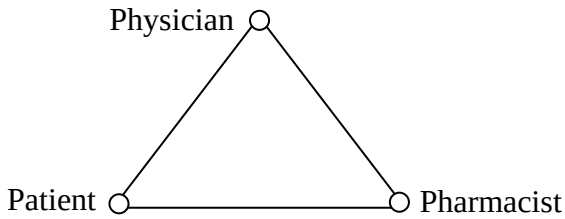

Figure 1 – Pharmaceutical care implied a triad relationship

In the triangle some links (relationships) between knots (actors) are rather stable and already investigated but one of them requires deep investigation because its implementation is the effect of a relative recent program aimed to improve primary care involving community pharmacies.

The Pharmacist-Physician is the one that has to be put under the lens of analysis because it is multifaceted and is strongly influenced by other interactions among players.

A valid measure of collaborative care may help explain different levels of success among collaborative health-care service interventions (Zillich et al, 2004).

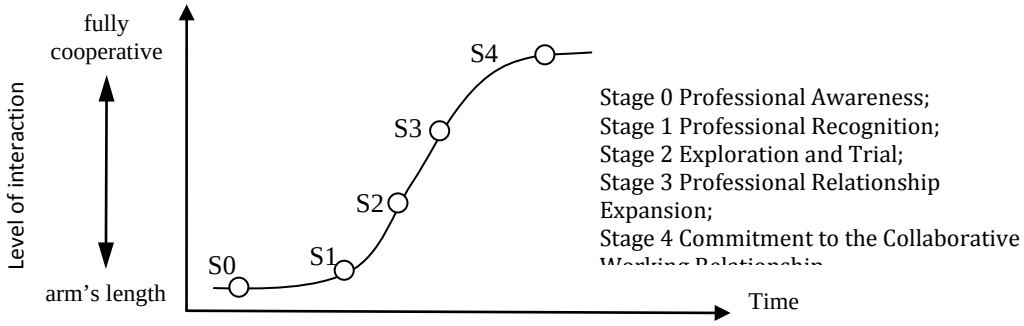

Figure 2 - Physician-pharmacist relationship life-cycle

At Stage 0, exchange is minimal and professionals are assessing mutual competencies from an arm's length perspective. At Stage 1 exchange is mostly unilateral or driven by one party: actors recognize the other specialization but prefer to have discrete and limited exchanges. At stage 2 pharmacist and physician try to interact in a more intrigued and mutual way but in a discrete framework, made up of growing exchanges but not in a continuous relationship. At stage three the two actors start to understand that the interactions are never ending and those exchanges become more bilateral and both parties are active. As the interactions progresses, they are experiencing a relationship thus they are creating a common base on which they share goals and experiences. Stage 4 represents a committed and sustained relationship characterized by bilateral communication and mutual trust. In this model, delivery of health-care services by a pharmacist expands as the stage of collaboration increases.

This model has been tested on the context of 340 primary care physicians in the state of

Iowa (Zillich et al, 2005). Although tested from the side of physicians only it reveals clearly the nature of trustworthiness of the relationship.

As represented in figure 3 trust impacts on the satisfaction (one side measure) with a regression coefficient of 0,40 followed by initiating behavior (r=0,32) and role specification (r=0,25).

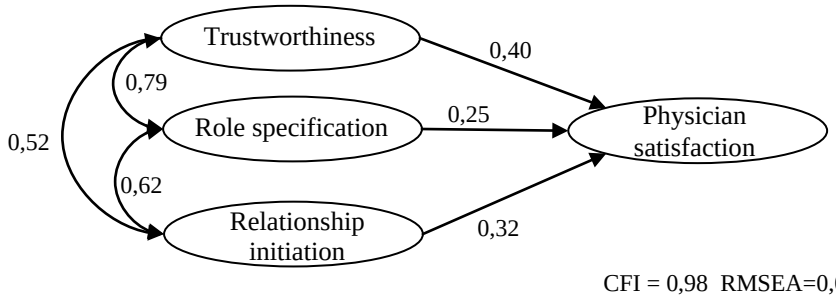

Figure 3 – Trust, Role and Relationship as determinants of the relationship (Zillich et al, 2005).

The three meaningful determinants loaded by a factor analysis of the explicit questions submitted to the physicians, reinforce the four stage of relationship evolution depicted in figure 2. One factor focuses on relationship initiation behaviors. This behavior refers to the actions of one party to determine the needs of another party; thereby facilitating relationship development. For example, suppose that a pharmacist is consistently answering questions about anticoagulation from a particular physician. To initiate a collaborative relationship, the pharmacist asks to meet with the physician to discuss mutual interest in a pharmacist-run anticoagulation service. This factor (relationship initiation) shows the willingness and desire of the pharmacist to open a dialogue with physician in order to improve competencies and give a more professional service to the patient in the pharmacy.

The second factor is a composite of items from trust, commitment, and communication. We label this factor “trustworthiness”. Conceptually, this factor encompasses a physician’s ability to trust a pharmacist’s word and expertise. That is, a high rating on this dimension means that if a pharmacist says he/ she will be able to perform a particular task or role, then the physician will trust that the job will be done as expected. In the

trustworthiness factor there are single items on commitment and two-way communication. Previous research has reported a positive association between trust and commitment (Morgan and Hunt, 1994; Moorman et al.,1992), as well as trust and two-way communication (Anderson and Weitz 1992). Trust, or confidence in another's abilities, can result in greater dialogue about problems encountered during patient care. Similarly, once a physician has developed trust in a pharmacist, he or she is more likely to be committed to interact with that pharmacist in the future (Morgan and Hunt, 1994).
The third factor is a mix of items representing dependence of practitioners on each other and negotiating acceptable activities for the practitioners. The authors labeled this factor as "role specification". This factor addresses the interactions between pharmacists and physicians in which they reach agreement on roles and responsibilities for each other in caring for mutual patients. The more equitably the roles are assigned, the more balanced will be the dependence of the practitioners on each other.
The three factors can be seen as a proxy of the stage model thus relationship initiation can represents stage 0-1, Trustworthiness are steps 2 and 3 and finally Role specification is step 4.
So initially the relationship is probably asymmetrical as pharmacists need cooperation and physician is the owner of the therapeutic plan for the patient.
Then the interaction between the two professionals probably can help to make more balanced the relationship and move it to a more symmetrical power confrontation.
In this paper we want to investigate these topics and explicitly to deepen the nature of asymmetrical power and its evolution associated to the relational stages.

Research aims

Charles et al. (1999) with the goal of studying the condition at the base of the relationship between the physician and the patient suggested that there could be basically three main approaches to the patient relationship management. First of all the physician can have a paternalistic approach with the patient; this means to have a one-side communication with the patient imposing, without any sort of interaction, diagnosis and then therapy and treatment follow up.

At the opposite side there could be a different perspective in which the physician adopts a total open and participative dialogue with patient (called shared model). The patient is active in each step of the health care process and consequently is more committed and responsible.
In between these two opposite approaches there could be many other combinations and mixture of the previous two. The average can sound like the one in which the physician makes the diagnosis autonomously and decide therapy and treatment in accordance with patient's feeling of his/her capability to cope with it.
This is called by the authors the informed model thus the doctor who has the knowledge guides the patient toward the definition of a viable therapeutic path.

Taking this as an assumption we try to include it in our analysis as an antecedent concept of the relationship among the triad: patient, physician and pharmacist and therefore to interpret asymmetrical power in the dyad Physician-Pharmacist as influenced by the style of conduction of the treatment process by physician.
In detail the following model outlines potentially different approaches that can be adopted in the wider relationship of actors involved in the patient's cure.

	Paternalistic Model	Informed model	Shared model
Analysis & Diagnosis	One Way	One Way	Two Way
Therapy	Doctor alone	Patient	Doctor and Patient
Treatment	Doctor & Pharmacist (in subordinate position)	Patient & Pharmacist (if required)	Doctor, Patient & Pharmacist
Prognosys	Doctor	Patient	Doctor, Pharmacist & Patient

Figure 4 – Physician's models of cure management

Since this model puts the physician in the driver's seat as he/she is the owner of the process, at least as regards the clinical point of view, it can also be employed as mirror

for the analysis of power between physician and pharmacist; the focal point of our analysis.

Descending from the model built on the Charles et al.'s construct (paternalistic, informed and shared model of interaction in health care) we want to investigate the power in the dyad relationship as associated with the approach of patient's cure path defined and conducted by physician who is the owner of the entire process.

Here therefore some research propositions can be formulated:

1) If physician conduct of patient's cure process is "paternalistic" the relationship between physician and pharmacist will be authoritarian in a way that the first will foster a compelling approach of the latter to follow strictly some defined protocols without any opportunity to customize it on the pharmacist's perception of the benefit for the patient. In this scenario the level of power exercised by the physician could be the highest in order to maximize compliance.
2) If conduct of cure path is inspired to an "informed model" then the dyad (physician and pharmacist) will have a limited overlap in decision taking since the real owner is the patient. The physician will leave freedom to choose to patient and consequently limited constraint to pharmacist's cooperation for the sake of the patient. In a way, the two professional operators will have total autonomy and independence and therefore there could be also competition in their advice to the patient. The solution or convergence of these potentially competitive advises is in the hands of the patient who is the real owner of the process. The dyad (pharmacist and physician) will have a balanced equilibrium of forces but no real strong contact because the strategy of cure is not top-down but is made by the interaction and complicity of the patient who defines each action step by step.
3) If conduct of cure path is inspired to a "shared model" then the dyad (physician and pharmacist) will have a balanced relationship open to confrontation, competition in the vision of treatment and also cooperation in helping the patient. So probably this is the best situation to have balanced power symmetry in the dyad although the physician has an evident superiority as regards the clinical side of the cure.

In order to confirm or confute these propositions we have conducted an explorative investigation aimed to assess the perception of the pharmacists towards the relationship with physicians.

Physician-Pharmacist Relationship

The picture of the relationship has been taken from the perspective of the pharmacists for many reasons. First of all this is a first attempt to investigate the topic, at least in Italy, notwithstanding previous international experiences have focused on the dyad without reframing the relationship from the physician strategic conduct of the patient's cure process (Snyder el al 2010). Although cure process is directed by physician, the initiation of the relationship is in the hands of the pharmacists so it is pivotal to start from their perception.

Finally this is an explorative research which has to validate the feasibility of the point of departure that is the centrality of the definition of the strategy of cure conduction by the physician.

We have subjectively selected, from the circle of acquaintances, three pharmacists who normally interacts with physicians and asked them to select three cases of patient's cure; one from the paternalistic model, another from the shared one and the last one from the informed.

We presented to the participants the Charles et al. (1999) model of physician strategic interpretation of the cure path and asked them to select among their completed experiences three different cases in a way to get finally three cases per each physician approach (paternalistic, informed and shared).

Per each case we asked the pharmacist to describe:

1. The strategy to conduct the cure process defined by the physician
2. The essence of the dyad relationship with the physician
3. The relationship between the pharmacist and the patient influenced by the strategy of conduct

The method followed to collect data is not statistically rigorous as the three pharmacists in the sample have been selected subjectively by the author among pharmacists already personally known.

The face-to-face interviews, which have had a length at average of 30 minutes, have been taped and successively transcribed. Narrative of the single side description of the nine cases (3 interviews by 3 cases) have been successively synthesized in order to fit the model presented in figure 4. After a comparison among the three cases per each of the three approach models we framed a qualitative picture as proposed by pharmacist's perception. The outcomes of this synthesis can be taken in consideration as an intuitive insight of the framework without any possibility to generalize it.

Exploring the "paternalistic" approach

The three pharmacists converge on the description of the three cases reported as paternalistic. In all of them the physician had a strong control over the cure process assessing diagnosis and therapy starting from his experience and with a limited interaction with the patient, except for the anamnesis and the description of symptoms.

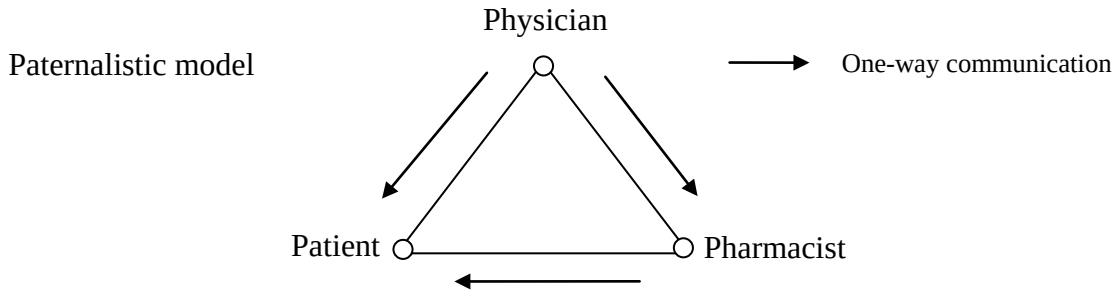

Figure 5 – The relationships in a "paternalistic" model cure path

When first contacted by the pharmacist, the physician clearly reported the approach of the patient, letting the pharmacist to understand that physician is the owner of the process. All the three pharmacists told us that Physicians stated, from the first contact, that they had the responsibility for treatment and that the support offered by pharmacy should have been considered ancillary. Two of the Pharmacists reporting this case (paternalistic model), have also found the underlying reason for this authoritarian behavior in the circumstance of the acclaimed disease (chronic illnesses). One reported that for him the Physician's approach was too severe compared to diagnosed patient disease but notwithstanding this he decided to align his behavior.

The three pharmacists, as a consequence, have adopted a compliance approach. One said that complying with the physician can be seen reductive in creativity and not professionally satisfying but at the same time it can be seen a great shelter from the risk incurring in professional errors since for the conduct of treatment is responsible the physician and in second position the pharmacist.

The compliance behavior of the pharmacists toward the physician's is rather regressed in the relationship with the patient. In order to assure the paternalistic strategy defined by the physicians, pharmacists adopt a one-way communication with the patient redirecting any instances of explanation to the doctor who is responsible for the cure. In this constraint two pharmacists showed some reluctances, as this approach can alter the classical open and collaborative behavior they have in relation to their customer base (patients served in the pharmacy). On the other hand one of two has also told us that any divergent approach does not pay for the service and generate potential misalignment and, in complex situations, also short-circuit in the wider triad relationship. For this reason it's better that the pharmacist would adopt a "take it or leave it" approach in relation to the request of compliance coming from the physician.

Exploring the "informed" approach

The informed model is devoted for the treatment of patients who are evaluated as capable to manage by themselves a therapy protocol. Physician's strategy is designed to offer the patient the best diagnosis in a way he can recognize the therapy which is best fitting to his or her personality.

Pharmacists involved in the survey affirm that they have recognized the informed approach from the profile of the patient defined by the physician.

The most recurrent portrait outlines a patient who is perceived strong enough to customize the treatment and rather confident to reject authoritarian or other-directed guidance.

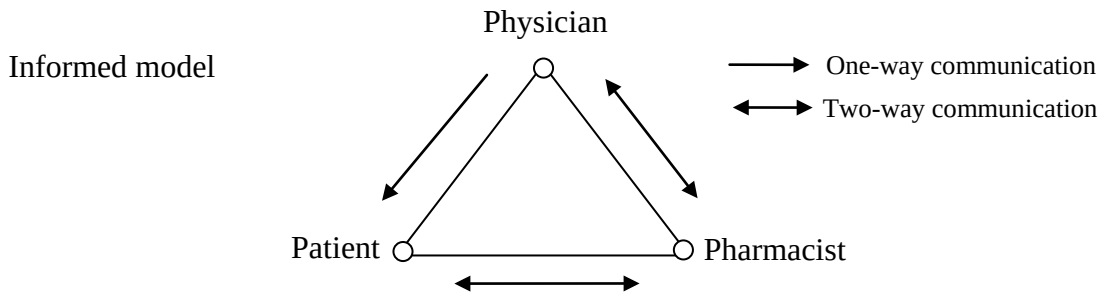

Figure 6 – The relationships in an “informed” model cure path

Pharmacist is more inclined to interact with the physician and feel the freedom to suggest feed-back as regards the evaluation of the therapy protocols emerging from supporting the patient during the treatment phase (surveillance and compliance).

In this model respondents affirmed that they were highly committed to look for cooperation from the physician since they felt engaged by the patient. This cooperation was not without any cost since pharmacist had to accept a burden of risk related to the failure of revised plan of treatment negotiated with the patient and presented to the physician.

On the other hand, in this perspective the self-esteem of professionalism of the pharmacist was higher and consequently the level of trust was influenced positively or negatively in accordance to the effect on the final prognosis. This reverberated directly in the relationship with the patient. When pharmacists evaluate a more open approach of the physician in the conduction of the patient cure, the relationship with the patient is more inclined to dialogue and two way communication. Pharmacists suggest that in this scenario they employ trust resources to leverage the relationship with patient in order to become more interesting at the eyes of the customer.

Exploring the “shared” approach

The model is inspired to open collaboration in all the links existing among the actors.

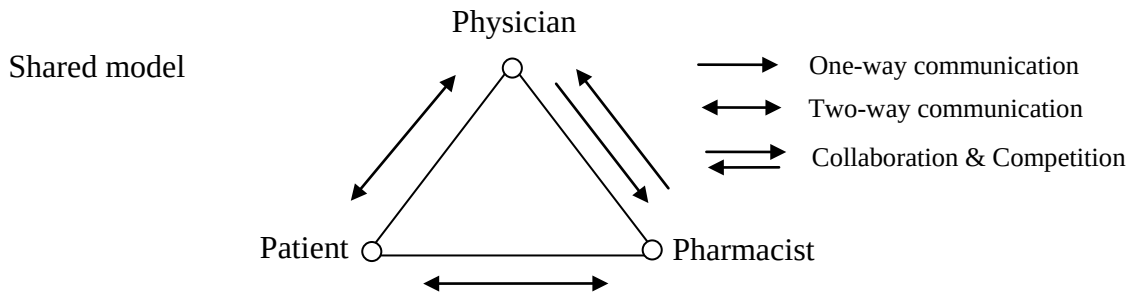

Figure 7 – The relationships in a “shared” model cure path

Physician assesses the capability of the patient to participate actively in the cure process. Therefore he/she is ready to accept a context in which confrontation, flexibility and non authoritarian are daily routine. When pharmacist detects a similar approach of conducting the cure process feel free to collaborate at 360 degree. Two respondents indicate that, in this situation of wide field of openness, competition can coexist as well aside the collaboration with the physician.

They compete in a way they struggle for interpreting and servicing better the patient. In this model the tension in relationship between physician and pharmacist can be elevated and can create conflicts. Conflicts arise when the two professionals have different view about the treatment of the patient. One respondent told us that he had confrontation with the doctor for a patient. Physician was irremovable when ask to change the cure for a patient who had had adverse effects from the combination of one treatment for diabetes and another for hypertension. He stated that it will take time to see the effect of the cure when pharmacist pointed out the short term negative effect on the health of the patient. This example shows how pharmacist is strongly involved in the process of cure and has to count on the trust base resources to face the confrontation with the physician.

On the other hand this model gives the pharmacist the wider opportunity to create an open and franc relationship with the patient who nurtures a relational feeling of the pharmacist as the counselor and the supporter for the treatment.

It is out of discussion that this position exposes the pharmacist at the higher level of risk and responsibility in case of treatment failure and poor or unsatisfactorily final outcome.

One pharmacist among the three interviewed admitted that sometimes it’s better for the pharmacist to intervene in a process of cure managed by a paternalistic approach where

his or her responsibility is limited to perform a compliant service to the patient and the physician.

Main results

The pharmacist's beliefs and attitudes play an important role in their intentions to collaborate with physicians. The findings suggest a strategy that involves collaboration to improve medication adherence and this can be most effective (Kucukarslan et al. 2010).
Although this analysis has no statistical validation and is explorative in the domain of physician-pharmacist relationship some consideration can be proposed.
First of all the three propositions postulated as research questions for this paper can be confirmed by the cases reported in the previous chapter. The style of conduction impressed to the cure path by the physician has a great impact on the relationship with the pharmacist. Since the first is a predictor for the latter it is necessary to investigate the model of cure chosen by physician to set up and improve the physicians-pharmacist relationship. The relationship between physician and pharmacist is also a predictor for the relationship with patients and it can become a truly constraint for pharmacist.
Generally speaking pharmacists try to create an open relationship with patient. We have to remember that for a pharmacist, the patient is also a customer and therefore all the rules of relationship marketing can be applied to their encounter: trust, empathy, loyalty, collaboration, etc..When pharmacist faces the case of patient whose cure path is conducted by a paternalistic approach he/she has the need to coordinate two potentially colliding behaviors. From one side the rigid clinical approach toward the patient which is descending from the physician paternalistic model and, on the other side, the flexible approach which is consequent to the nature of the commercial relationship and the servicing encounter. Differently from the context of the interaction with a physician, the patient requires flexibility from the pharmacist; flexibility that it is hardly playable if the cure path is inspired to a paternalistic model. In this constraint pharmacist is like to be caught in the middle of two fires; compliance with the physician adopting an authoritarian approach? or maximize satisfaction of the customer/patient adapting the approach to the status of the encounter? This constraint highlights a great role of the pharmacist as negotiator among different needs and expectation. Extending the scope of

the activity to the compliance and medication adherence, imposes the pharmacist to collaborate with physician and therefore to become a mediator between divergent forces being the pivot between patient and physician. Bryant et al. (2011) just arrived to the conclusion that although collaboration between the two professionals can improve strongly the quality of health care service provided by primary care, one big issue is the high withdrawal of the pharmacists to the participation of project of collaboration. Withdrawal that can be justified in the difficulty for a pharmacist to wear the negotiator dresses.

Another outcome of this explorative investigation is the competency of risk managing (O'Donnell, 2005) which must be kept by pharmacist. Monitoring of treatment adherence activated by pharmacists can expose them to the assessment and evaluation of efficacy of the treatment and therefore the possibility of suggestion for further revision in the cure path. Although the revision of the cure is a task of the physician, pharmacists must support evidence of their assessment and therefore expose him/her to risk of failure.

It is understandable that some respondents to our survey admitted that they prefer to acquiescence with physician in order to avoid increase in risk taking.

Finally this first investigation highlights the importance for the pharmacists to learn how to manage relationships facing problem of colliding tendencies like coerce and concede (Ritter and Ford 2004) or managing conflicts among participants of the triad (Gadde and Hakansson 1993) which can be an important ingredient in the promotion of innovation and hence is a dynamic force in the relationship, or finally stimulate collaboration and information exchange from the physician using trust base resources (Hakansson 1982). Consequently the knowledge of the pharmacists to create and nurture resources of trust inside the health care operators must be another ingredient of the receipt to embrace successfully the evolution of the profession in the next future.

Limitation and Future research

This research has envisaged potential dark areas of the collaboration between pharmacist and physician, but at the same time has shown key elements for future improvement.

To validate and consolidate this insight it could be pivotal to deploy a quantitative research to understand the sentiment of the pharmacists toward collaboration like the one launched under the CWR model (McDonough and Doucette 2001).

As a second stage of investigation it could be interesting to understand how relationship can be managed at best. In this direction we have to suggest the adoption of the approach of Snyder et al. (2010) who have performed an investigation from successful pairs of community pharmacists and physicians in order to offer a comparative insight of the exchange variables and expand research on models of professional collaboration.

Furthermore the extensive research should be designed starting from the ARA model which recognizes in actors, activities and resources as the basic elements of a relationship. The experimental investigation has focused the attention on the Actor side of the model but has ignored the other two factors at the foundation of the relationship.

Finally to understand better the potentiality and the constraint of Collaborative working relationship among the actors of the primary care it could be pivotal to involve in the analysis the point of view of the patient which is at the end the customer and who has to appreciate the collaboration as a way to improve his/her quality of life.

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